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FROM THE AMERICAN PEOPLE

Subject: **Pre-Solicitation Notice, RFI # 386-07-004**

Dear Interested Parties,
This is to inform you that the USAID has released a Draft Statement of Work for careful review and comment. The new 5-year program in Maternal and Child Health Sustainable Technical Assistance and Research (MCH-STAR) also known as SAHYOG –Knowledge Management Creation will be in Health Arena.

All the materials composed to date may be found at http://www.usaid/gov/in under "Working with us" sublink. The USAID India mission intends to hold a Pre-Solicitation Conference on Thursday morning, May 3, 2007 in Delhi from 08:30-12:30am at the following location:

The Claridges Hotel
12 Aurangzeb Road
New Delhi – 110011
India

USAID will provide (post) further updated information as it becomes available. Individuals and representatives of for-profit firms and NGO's are strongly advised to pre-register on or before Wednesday, April, 25, 2007 via an email to IndiaRCO@usaid.gov with following information – name of attendee, company represented, street address, email address, telephone number, and facsimile number.

Questions and comment must be addressed to the same email account or directly to me at marcusjohnson@usaid.gov.

The potential value of this tender (Contract) is approximately US$13-16million over a 5 year period.

The session will be interactive with Agency procurement and technical officers on hand to entertain questions and provide their perspectives to attendees. All entities listed in the draft Statement of Work will be specifically invited to send knowledgeable representatives. Electronic audio or video recording devices are not permitted.

Sincerely,
/s/
Marcus A. Johnson, Jr.
Regional Contracting & Agreement Officer

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DRAFT Statement of Work

MCH Sustainable Technical Assistance and Research (STAR)

1. Background

1.1 The Maternal, Newborn and Child Health and Nutrition Scenario in India

Improving the health of women and children in India is paramount for India at this stage in its development. The data shows the challenge:

- 20 percent of the world's births are in India;
- 20 percent of the world's maternal deaths are in India (the most of any country in the world);
- One woman dies every five minutes in India (more than 130,000 deaths a year) from causes related to pregnancy and childbirth;
- 25 percent of the world's child deaths are in India;
- Approximately half of all children under the age of three in India are malnourished; and
- Among children 12-23 months, only 43.5 percent are fully immunized.

Causes of Child and Maternal Death and Child Malnutrition in India are Preventable and Treatable.
The major causes of under-five and maternal deaths are preventable and treatable. In the case of children under five, one half of the deaths occur during the neonatal period (the first month of life), yet the major causes of morbidity and mortality are known and many feasible life-saving interventions exist. Some of the main causes of death of older children under the age of five include diarrhea, pneumonia, measles and other infections. For this age group, life-saving interventions also are known.

For women, the main causes of maternal death also reveal that saving these lives does not require extraordinary interventions or technology. The main causes of maternal death are hemorrhage, anemia, sepsis, complications from abortions, obstructed birth and toxemia. The low use of health services partly illustrates why these continue to cause so many deaths. Only 50 percent of mothers received three antenatal care visits for their last pregnancy and only 22 percent consume iron/folic acid tablets for 90 days or more. Strikingly, only 41 percent of deliveries take place in facilities and, at best, 48 percent of births are assisted by a trained health professional.

Malnutrition plays a major underlying role in both child and maternal health. Malnutrition is associated with more than 50 percent of childhood deaths and

directly affects the severity of diseases such as measles and diarrhea. The impact of malnutrition is reflected in child health statistics including high levels of stunting, anemia, and maternal under-nutrition. The causes of under nutrition include delayed initiation of breast-feeding, early termination of exclusive breast-feeding, low vitamin A and iron/folic acid intake, and inappropriate complementary feeding, poor hygiene-related practices and related morbidities – diarrhea and intestinal helminthes.

During the past 25 years, mortality for children under five has declined in India, demonstrating that progress can be made in child survival at a national level. Yet, according to the Human Development Report 2005, the slower annual reduction in the Infant Mortality Rate[1] indicates that India has not been able to convert its substantial globalization success into human development. India's high maternal mortality ratio[2] (327 per 100,000 births) reinforces this claim.

The role gender plays in MNCHN deserves special attention. There has been a sharp decline of almost 40 points (from the 1981 census to 2001) in the child sex ratio for girls. While neo-natal and infant mortality rates in boys and girls favor girls or are comparable, respectively, the under-five mortality rate is significantly higher for girls. This clearly establishes that environmental influences, including social values that lead to girls receiving low value and poor care are a significant factor in girls' health. These inequities continue throughout the life of a woman. For a woman in India, the social distance is often a far greater gulf than the physical distance to a health facility. Also commonplace, an Indian woman does not have the autonomy to take decision about the health and well-being of her family and herself. Gender interplays with caste, class, religion, age, geographical location economic and health status to further intensify a woman's vulnerability.

1.2 Status of Maternal, Newborn and Child Health in India's Northern States – The Empowered Action Group States (EAG)

Despite gains at the national level, clear differences in child mortality rates still exist between the states, between gender and between economic groups (Groups with lower economic opportunity have the highest child mortality rates and the greatest needs). MNCHN problems are especially severe in India's Northern States. The states of Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Rajasthan, Orissa, Madhya Pradesh and Chhattisgarh contribute significantly to the country's poor MNCHN status. These eight states, collectively referred to as

[1] Infant Mortality Rate (IMR): The infant mortality rate (IMR) is the ratio of the number of deaths among children less than one year old during a given year to the number of live births during the same year. It is expressed in per 1000 live births. Whereas India's rate is 57, China's is 26 and the U.S.' (the most populous developed nation) is 7.

[2] Maternal Mortality Ratio (MMR): The number of women who die while pregnant or within 42 days after pregnancy, form any cause related to or aggravated by pregnancy per 100,000 live births in a given year. Formula is MMR= # of maternal deaths in a year/100,000 live births in a year.

the Empowered Action Group (EAG) states by the GOI, constitute 45 percent of the population and have similar, poor MNCHN indices. The National Rural Health Mission, RCH II and their assistance mechanisms like the National Health Systems Resource Center (NHSRC) are focused first and foremost on improving basic health indicators in the EAG states.

USAID's MNCHN approach has traditionally focused its efforts in select northern states (Jharkhand and Uttar Pradesh). The significance of focusing on states such as Uttar Pradesh (UP) is borne out by the state's MNCHN indices. Whereas the national average for infant mortality and under-five mortality[3] are 57 and 74, in UP (pop. 170 million – equivalent to the population of Brazil) the averages are 30 and 65 percent higher, respectively. UP accounts for one quarter of all child deaths in India and India accounts for 25 percent of the estimated 10.5 million children who die each year globally. In other words, more than 650,000 children die each year in the UP alone. Based on this, for any USAID effort to impact India's health statistics, it must target the most vulnerable in UP. USAID also focuses on Jharkhand, where health indices are poor but where there is political and bureaucratic commitment to see rapid improvement. Focusing in these areas would positively affect not only the local population. It also would have impact at the national level and is critical to India's Millennium Development Goals, which call for reducing the IMR to 27, the U5M to 42 and the MMR to 109 by 2015.

The very nature of MCH STAR, which will look at operations and policy research, analysis, advocacy and technical support, means it will aim to have a national-level influence. MCH STAR will attempt to influence national-level MNCHN policy based on evidence-based research and analyses. Nonetheless, MCH STAR will still maintain a geographic focus in the EAG states and specifically in USAID's MNCHN focus states of UP and Jharkhand.

1.3 Government of India (GOI), MNCHN and the Need for MCH STAR

In April 2005, the Government of India launched the National Rural Health Mission (NRHM) to highlight the importance of health in the process of economic and social development. This program follows the earlier Child Survival and Safe Motherhood, Reproductive Child Health (RCH) I, and RCH II programs, and incorporates the RCH II program as its flagship activity. In February 2007, the GOI recommitted itself to addressing the country's health issues. The GOI's proposed budget for 2007 - 2008 calls for a 21.8 percent increase in health funding, including an increase in NRHM funding to $2.21 billion annually.

[3] Under Five Mortality Rate (U5M): The probability of dying between birth and exactly five years of age, expressed per 1,000 live births.

The goal of the NRHM is to help improve availability and access to quality health care by people, particularly for those residing in the rural areas, the poor, women and children. NRHM:

- Outlines necessary corrections in the basic health care delivery system;
- Spells out inclusion of other determinants of good health (e.g. nutrition, sanitation, hygiene and safe drinking water);
- Corrects regional imbalances in health infrastructure in Northern and Eastern India;
- Proposes increased public expenditure on health;
- Pools public health resources;
- Integrates organizational structures;
- Optimizes health and human resources;
- Decentralizes management of health programs to the district level; and
- Promotes community participation and ownership.

The GOI acknowledges the difficulty of implementing NRHM. In January, 2007, the GOI concluded in its 3rd Joint Review Mission (JRM) of its flagship NRHM program, RCH-II. The JRM – a GOI, donor and partner review of the progress against RCH outcomes – indicated that none of the states in India will achieve the RCH-II goals related to MMR by 2010 and only six to seven states will achieve the Infant IMR and Total Fertility Rate (TFR)[4] goals. Moreover, the government struggles to expend money marked for health services. By the end of second quarter of the FY 06-07, the actual expenditure of the child health budgets was estimated to range between zero and 15 percent of planned expenditure at the state level and a meager two percent of planned expenditure at the national level – meaning much of the money allotted for children's health services is not being expended.

One important gap hampering NRHM's success is the lack of technical assistance to support effective implementation of evidence-based, sustainable MNCHN activities. NRHM's Framework for Implementation clearly recognizes this. It states the need for:

"Effective monitoring of performance, support for capacity development at all levels, and sharing the best national and international practices…"[5]

According to the NRHM Framework for Implementation, the Indian central government is to fill this role. To meet the need for technical assistance and

[4] Total Fertility Rate (TFR): The **total fertility rate** or **total period fertility rate** (TPFR) of a population is the average number of children that would be born to a woman over her lifetime if she were to experience the current age-specific fertility rates through her lifetime. It is obtained by summing the age-specific rates for a given time-point. The TFR (or TPFR) is a better index of fertility than the Crude birth rate (annual number of births per thousand women of childbearing age) because it is independent of the age structure of the population.

[5] *National Rural Health Mission, Framework for Implementation (2005), page 22.*

the dissemination and implementation of best practices, GOI formed the National Health Service Resource Center (NHSRC). The NHSRC is tasked with managing and facilitating access to:

- A pool of institutions and individuals that deliver high-quality technical assistance;
- Capacity development for achieving the health outcomes and objectives via government and non-government institutions and organizations at central, state, district and sub-district levels;
- Evidence-based insights on wider determinants of health outcomes for planning of the health sector at the national, state and district levels;
- Efficient implementation of the NRHM at central, state, district and sub-district levels;
- Monitoring and evaluation systems based on latest innovations and technology;
- Knowledge management, documentation and dissemination of knowledge and experiences, as well as good practices in health systems in India and across the world;
- Policy advice to the central and state governments, including on matters specifically pertaining to the health and family welfare sector; and
- Analytical work to continuously improve the planning, implementation, monitoring and review of the health sector reforms. [6]

The NHSRC will need access to a pool of health sector technical assistance institutions and individuals that can provide these services specifically to the MNCHN sector. These institutions currently do not exist. USAID's MCH STAR activity will identify potential institutions and help strengthen their capacity to meet this need.

Furthermore, the GOI has strongly supported the creation of the Public Health Foundation of India (PHFI). PHFI was created to redress the limited institutional capacity in India for strengthening training and for research and policy development in all public health sectors. Its goal is to create public health training institutes throughout India – providing post-graduate courses and preparing India's next generation of public health professionals. In addition to designing and delivering post-graduate courses, PHFI will strive to impact government employees in the health sector. It will provide classroom teachings, teaching methodologies, demonstrations, field work, assignments, self learning, computer aids, case studies, critical thinking exercises, seminars and role play. Furthermore, PHFI Institutes also will conduct research relevant to individual states, regions and the country as a whole. Determination of research priorities shall be under the purview of the individual public health institutes with input from both the state government and other public health experts.

[6] Rules and Regulations of the National Health Systems Resource Center, Section 5.1.

The creation of PHFI and NHSRC demonstrate that the GOI demands the type of service MCH STAR will provide. These institutions also demonstrate the GOI wishes to have this service readily available from an indigenous source. MCH STAR is designed to address this recognized gap and to accelerate progress where remedying activities have already begun.

1.4 USAID/India's Child Health, Maternal Health and Nutrition Efforts: Past, Present and Future

USAID has a long and rich history of high quality, responsive technical support in MNCHN matters in India. This is a product of USAID's network of global projects and experience, its technical focus on supporting MNCHN interventions in India, and its access to and relationships with both U.S. and Indian universities and research organizations. As a result, the GOI recognizes USAID as a partner in its MNCHN initiatives and an important source for MNCHN technical assistance.

USAID's experience in MNCHN also is illustrative of the larger problem of MNCHN technical assistance in India. USAID currently oversees more than ten separate MNCHN assistance activities and projects. These numerous activities – divided among research, micronutrients, service delivery, immunization, and others – present challenges to coordination across sectors, are unwieldy in terms of management and do not provide for an integrated and comprehensive approach to technical support in MNCHN matters. The programs' effectiveness often suffers from a fragmented approach to technical assistance and the lack of a dominant authority and source for the provision of comprehensive and high quality MNCHN technical assistance. Nonetheless, the USAID program for MNCHN in India has had considerable successes – contributing to positive results in its focus areas.

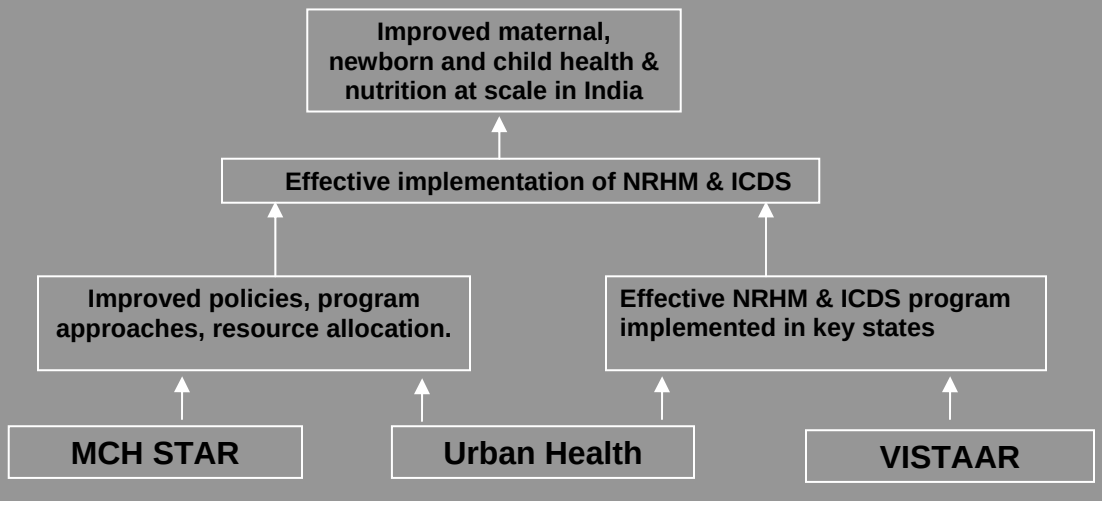
In anticipation of MCH STAR, USAID's current MNCHN technical assistance and research activities are winding down or will wind down over the MCH STAR period of performance. One aim of MCH STAR is to consolidate the Mission's MNCHN management structure and to increase the integration and coherence of overall MNCHN technical support. Doing so would allow the Mission to improve its internal management of MNCHN activities and would help India fill a large gap in its approach to MNCHN.

USAID/India's MNCHN strategy will be executed by three core activities. Table 1.1 illustrates this strategy and how USAID MNCHN activities support it.

The first of these activities is Vistaar. Launched in 2007, Vistaar explicitly

Table 1.1

Results Framework



addresses the effective implementation of NRHM and ICDS programs in two key states. It accomplishes this through demonstration, learning and support for the scale-up of proven MNCHN approaches in rural areas and small towns in the states of UP and Jharkhand, and at the national level through NRHM and ICDS. The urban program, only five years old, is implemented by the UHRC. This program focuses on improving MNCHN indicators among the urban poor through technical, systems and policy interventions. The third project, MCH STAR, will help India contribute to improved policies, program approaches and resource allocations via institutions that specialize in MNCHN technical leadership, policy analysis and advocacy.

It is easiest to think of the activities this way: Vistaar supports the implementation of the NRHM through the identification and scale up of effective programs at the local, state and national levels; UHRC addresses systems and MNCHN issues specific to urban poor settings; and MCH STAR provides high-level MNCHN technical inputs for effective policies and implementation of the NRHM.

2. Detailed Technical Requirements

2.1 Activity Description

2.1.1 Project Goals, Objectives and Results

Goal:

The overall goal of MCH STAR is to improve maternal, neonatal and child health and nutrition in India among poor and underserved populations through effective programs that address priority issues and are guided by appropriate policies.

General Objective:

Sustainable Indian institutions provide technical leadership and critical technical inputs to public and private sector programs in India in maternal, neonatal and child health and nutrition matters through technical assistance to programs, policy analyses and advocacy, and operations, applied and policy research.

Project Principles:

1. Focus on the major causes of maternal, neonatal and childhood diseases and malnutrition, and their proximate determinants. This activity is meant to contribute to improved maternal, neonatal and child health and nutrition and will stay focused on these priorities.

2. Promote evidence-based programs and policies to address MNCHN needs. This activity will promote the use of scientifically sound evidence in program and policy formulation and collective decisions through the creation of new information (through operations and policy-related research), the effective dissemination and promotion of discussion and action related to new and existing information, white papers and policy analyses, and other means as appropriate.

3. Address critical gaps and constraints. Through consultation, priority setting exercises with all stakeholders and other means of identifying key gaps and constraints to programs, this activity will identify a priority agenda for operations and applied research, program and project evaluations, technical assistance and related actions that address the most critical gaps and constraints in current programs and policies.

4. Focus on poor, vulnerable and marginalized populations, including applying a gender lens to all activities and analyses. As there are sharp disparities in the health status between economically and socially

advantaged populations and those not so, this activity will focus on programs and policies that are designed to reach those populations with the greatest public health need. It will adopt and sharpen USAID's focus on social determinants of health status and operational issues for reaching poor, vulnerable and underserved populations. This includes ensuring that the impact of gender dynamics is properly understood and addressed in regard to these determinants and issues.

5. Focus on programs and policies that benefit populations with the worst health indicators. This includes the 200 poorest performing districts where NRHM will focus. These districts are within the critical EAG states – those eight states within NRHM where health status is poorest and progress has been slow. Among the EAG states, primary focus will be on Uttar Pradesh and Jharkhand.

6. Work with programs that will make a difference at scale in India. This activity will work with the RCH II, the NRHM and ICDS to provide support in key areas to improve program effectiveness and improve MNCHN at scale in India. These relationships of support to the national programs form the hallmark of this activity and all priorities and work will be developed through a process of close consultation and collaboration with these programs.

7. Build the capacity of Indian institutions that can provide technical leadership in MNCHN and continue to make contributions of the nature of MCH STAR's in a sustainable fashion in India. This activity will focus on providing key MNCHN support services in the near term while building the capacity of Indian institutions to continue to provide such services in the long term.

8. Improve the coherence and management of USAID-supported MNCHN technical support activities. MCH STAR will bring lines of work that have historically existed under many different projects under one umbrella, thus providing: increased management efficiency; financial efficiency; better coordination and realization of synergies between activities; reduction of redundancies; and improved focus on a smaller set of technical priorities developed through a rigorous process of GOI and stakeholder involvement.

9. Work closely and synergistically with other MNCHN activities and partners. MCH STAR will work with MNCHN partners, including but not limited to those funded by USAID, to identify opportunities and priorities for the provision of technical services, to avoid overlap and unintentional duplication, and to identify critical gaps that MCH STAR is well positioned to address.

Geographic Areas of Implementation:

MCH STAR will provide technical support directly to the National Rural Health Mission (NRHM), Reproductive and Child Health II (RCH II) and ICDS programs, so is expected to have national influence. As such, project activities will directly support improved programs that are focused on areas of greatest need -- specifically the 200 poorest performing districts in the EAG states (northern states with similar health problems and poor MCH indices – Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Uttar Pradesh, Jharkhand, Uttarakhand, and Bihar). State specific activities and on-the-ground research activities will focus on USAID's RCH states of UP and Jharkhand.

Main Results and Key Indicators:

1. Applied, operations and policy research priorities established for maternal, neonatal and child health and nutrition in India.
    a. Consensus research priorities established at the national level for maternal health, neonatal health, child health, maternal nutrition and infant and child nutrition through a process that involves all stakeholders including the GOI.
    b. Consensus research priorities established at the state level for at least two of these areas, in UP and Jharkhand.
    c. Consensus research priorities are reviewed and updated with all stakeholders annually, including reviewing progress in addressing priorities, at both the national and state levels.

2. Results of key applied, operations and policy research studies effectively disseminated to influence programs and policies.
    a. At least two major applied, operations, and/or policy research studies initiated annually.
    b. At least four small-scale applied or operations research studies initiated annually.
    c. Results documented and disseminated to all stakeholder organizations within four months of the end of field collection of study information.
    d. At least one national and one state consultation on new research findings held annually.
    e. At least one policy change annually where a major contribution of MCH STAR research can be attributed.

3. Information and platforms for evidence-based policy development are improved.
    a. At least two policy analyses or white papers produced annually.
    b. At least one policy consultation annually addressing one or more maternal, neonatal and child health and nutrition matter

convened or co-sponsored by MCH STAR or MCH STAR-supported institutions.

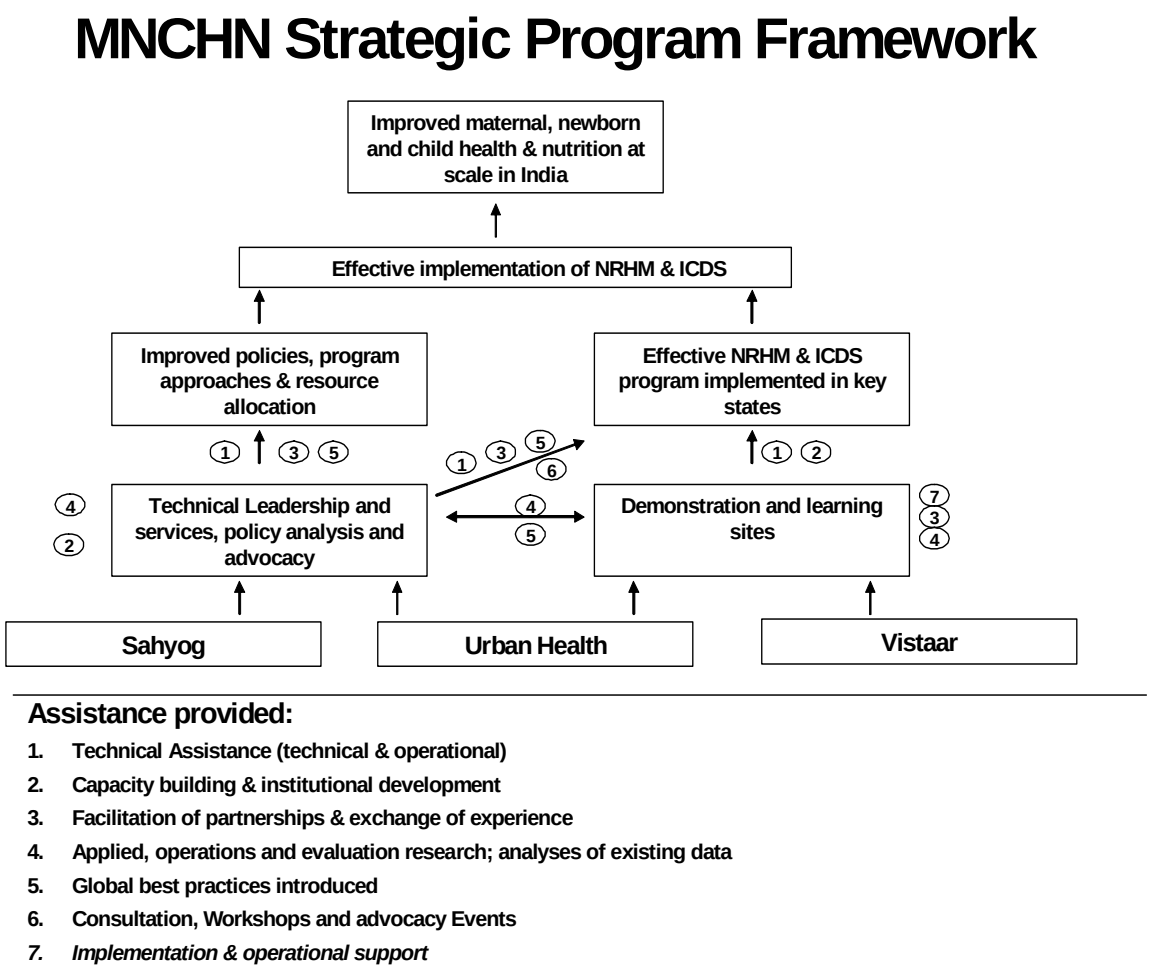
4. Programs are improved through the provision of well-informed and competent technical assistance at the national level.
    a. At least two full time equivalents of technical assistance are provided to the NHSRC.
    b. At least two MCH STAR-supported institution members are asked to participate and contribute in each NRHM/RCH II Joint Review Mission (JRM).
    c. MOHFW and MWCD requests for specific technical assistance in MNCHN are fulfilled with timely, responsive, and high quality assistance.

5. Programs are improved through authoritative independent evaluations.
    a. At least one major program evaluation is conducted annually by MCH STAR-supported institutions.
    b. Evaluation scope, methodology and final interpretation of results are managed in collaboration with major stakeholders, including the GOI.
    c. Evaluation results are disseminated through a final report, peer-reviewed publication where appropriate, and a technical consultation.

6. At least two Indian institutions have the technical capacity, established relationships and financial health to provide these MNCHN technical services in a sustainable fashion.
    a. MCH STAR-supported partners convene, co-sponsor or their institutional representatives are invited as members of national working groups, task forces and similar convening's where maternal, neonatal and child health and nutrition are the subjects.
    b. Research reports are published in peer-reviewed publications.
    c. In the fifth year of the project, USAID funds constitute no more than one third of all funding for MNCHN activities.
    d. In the fifth year of the project, MCH STAR-supported Indian institutions will provide 90 percent of the MNCHN technical services demanded.

2.1.2 Overall Program Strategy

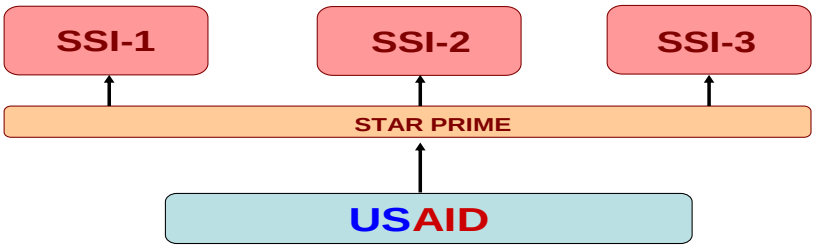
MCH STAR will support the overall MNCHN Strategic Program Framework, illustrated in the following figure:



The role of MCH STAR within this framework will be to implement the function of the lower left hand box – technical leadership and services, policy analysis and advocacy. The institutional strategy will be to support the capacity development of Indian institutions that may continue to provide these services in a sustainable fashion.

Program Approaches:

A. Capacity Building of Indian Institutions: Capacity building will be a hallmark of MCH STAR. It will have an intensive focus on working with two or more selected Indian institutions (i.e. the STAR-supported institutions) to build their capacity for technical leadership in MNCHN in the long term. In order to achieve this, MCH STAR will be organized with one prime contractor or grantee supported by USAID. The prime will work directly through the selected STAR-supported institutions to provide technical services. It also will build the STAR-supported institutions' sustainable capacity to continue providing services after USAID funding ends. The relationships between USAID, the prime institution and the STAR-supported institutions are illustrated in the following figure.



SSI – STAR-supported Indian Institution

The relative roles and relationships between the MCH STAR Prime and the STAR-supported institutions (SSI's) can be summarized as follows. The MCH STAR Prime will have overall responsibility for project management and, as such, will have a direct relationship with USAID. The MCH STAR Prime will be responsible for development and management of the work plan; capacity building assessments, plans and activities; developing and managing sub-agreements with the SSI's, including assuring compliance with reaching milestones and assuring deliverables. The MCH STAR Prime also will be responsible for identifying needs for technical assistance for capacity building or for strengthening the quality of products of the SSI's as well as to service MNCHN partners such as the MOHFW, MWCD and NHSRC, and will have primary responsibility for sourcing the TA from SSI's or other sources. The MCH STAR Prime will have final responsibility for quality control of all services and products of MCH STAR. The services of the MCH STAR Prime are time bound and expected to end when SSI's are sufficiently strengthened.

The SSI's will be the primary implementing agents for MCH STAR's MNCHN activities and services. This includes: provision of technical assistance; design,

approval, implementation, analysis and dissemination of operations, applied and policy-related research; design, implementation and dissemination of program evaluations; design, implementation and dissemination of policy analyses and white papers; and participation in or support or organization of forums, consultations, task forces, and working groups to build consensus priority setting for research and technical services and to review other crucial MNCHN matters.

b. Technical assistance to programs that work at scale in MNCHN: TA will be provided to RCH II-, NRHM- and ICDS-related endeavors. Subjects for technical assistance include all aspects of maternal, neonatal, and child health and nutrition and may include operational and systems issues that impede the effective implementation of MNCHN activities. Other recipients of TA may include other USAID projects, NGO's and private sector partners. Such TA will depend on the assessment of need, opportunities to fill a critical gap, and the ability to have an effect at scale in India. Technical assistance will be provided through international projects and sources, the STAR-supported institutions themselves, or from other sources in India. Preference will be to provide TA through STAR-supported institutions. As a general rule, TA for MNCHN matters funded by USAID will be facilitated and coordinated through MCH STAR.

c. Operations, applied and policy-related research, analyses of existing data, and program evaluations: MCH STAR will support improved programs and policies by providing new information through research, by re-analyzing existing data to answer key questions, and performing high quality independent evaluations of existing programs. Priorities will be established with the GOI and other major stakeholders and the activities will focus on producing high quality results in a timely manner. The information will be disseminated through reports, consultations, and workshops designed to bring the information directly into the program and policy dialogue and to inform decisions.

d. Facilitation of partnerships and exchange of experiences: In order for the activities of MCH STAR to be relevant, the project will never act in isolation. Activity priorities – from research to consultations to advocacy activities – will be established with the GOI and a wide array of important stakeholders in order to establish buy-in and ownership of the end users of information thus produced. MCH STAR will seek to support institutions and activities that have multiple donors where USAID, through MCH STAR, may play a strategic role in addressing specific needs and gaps, rather than creating institutional dependency on USAID.

e. Leveraging USAID resources to achieve large scale and long term public health improvements. As noted, national GOI programs will be a key focus of the activities of MCH STAR, with an aim to improve programs operating at scale. MCH STAR-supported institutions will be identified based on a set of

criteria that indicate their institutional and technical strength and diversity of funding sources – from both public and private sector sources. This will make it possible to strategically apply limited USAID funds on one hand, and on the other hand is an indicator of longer term sustainability of the MCH STAR-supported institution.

What's New in MCH STAR?

1. USAID funded technical assistance in MNCHN will be coordinated under one management structure – MCH STAR.

2. All MNCHN operations, applied and policy-related research priorities will be determined through a national process of priority setting that includes the GOI and all major stakeholders.

3. Building the capacity of two or more key MCH STAR-supported institutions to provide technical leadership in MNCHN in a long term, sustainable fashion will be a key focus and outcome of MCH STAR.

4. Increased emphasis on nutrition integrated into all USAID-supported MNCHN activities and technical assistance.

What MCH STAR <u>Will Not Do</u>:

1. Provide direct implementation and operational support to programs, beyond selected support required for operations and applied research activities.

2. Support investigator-driven research topics that are not the product of a consensus priority-setting exercise.

3. Support clinical research.

4. Focus exclusively on MNCHN technical issues without considering broader constraints to the effective implementation of MNCHN programs (e.g. social factors, management constraints, local governance issues).

5. Focus on improving food security.

6. Focus on supporting or monitoring ICDS or PDS food logistics and supplies.

7. Focus on hospital and tertiary care services

8. Apply resources where the effects cannot be closely linked to improving MNCHN at scale in India

2.1.3 Technical Approach and Activities

1. Capacity Building of Indian Institutions
    a. Identify Indian institutions with potential to develop centers of excellence in MNCHN technical assistance and research. As examples, include the Public Health Foundation of India http://www.phfi.org and IndiaCLEN http://indiaclen.org/index.htm

    b. Develop a specific capacity building plan for selected institutions, where the provision of programmatically relevant, high-quality technical assistance and applied research in MNCHN matters are the capacities to be developed and measured as outcomes. Support the implementation of this capacity building plan.
    c. Strengthen the capacity of these Indian institutions by facilitating alliances and cross learning, mentoring, problem-based technical assistance to ensure the highest technical quality and the institutional development to perform MNCHN technical tasks independently in the future.

2. *Applied, Operations and Policy Research*
    a. Develop and implement a plan for STAR-supported institutions to identify with the GOI, state governments, professional associations and other stakeholders key issues where evidence is required to support policy and program decisions, and
    b. Support the development of such evidence through conducting operations, applied and policy-related research, program evaluations and evaluation research, analyses of existing data (e.g. NFHS III), or translational research of established global best practices – in all cases implemented through MCH STAR-supported institutions and in collaboration with Indian institutions and implementing partners.
    c. Develop and implement a system to request research proposals, both from STAR-supported institutions and from other Indian institutions where it may be advantageous for getting the best research product, and for maintaining a productively competitive environment for research awards.

3. *Policy Analyses, White papers, and advocacy*
    a. Develop and implement a plan for the STAR-supported institutions to identify with professional associations, government and other stakeholders key issues where policy analyses, white paper, and advocacy efforts may improve the performance of the national program.
    b. Support the development of priority policy analyses, white papers and advocacy events.

4. *Technical Assistance*
    a. Develop and implement a plan for STAR-supported institutions to identify with the GOI, state governments, professional associations and other stakeholders key areas for technical assistance in MNCHN at the national level.
    b. Provide such technical assistance through the STAR-supported institutions, supplemented by other sources of TA where necessary. MCH STAR will coordinate all USAID-supported MNCHN TA from all sources.

Statement of Work

2.2 Identify MCH STAR Supported Institutions.

The applicant will establish requirements for institutions to qualify for selection as a MCH STAR-supported institution.

- Minimal institutional requirements include:
    - FCRA clearance;
    - An articulated institutional focus or mission that includes MNCHN and/or critical matters for improving MNCHN program effectiveness;
    - History of funding from at least three sources;
    - A history of performance in some or all MCH STAR technical-support areas (operations, applied, policy-related research; technical assistance to the NRHM, the MOHFW, state programs and MWCD/ICDS; organization and convening of national technical and policy-related meetings; and policy analyses and white papers – all aimed at improving MNCHN); and
    - An institutional focus that goes beyond narrow technical issues and includes social, behavioral, systems and community aspects of both treatment and prevention of MNCHN conditions.

- Additional selection criteria may include (but are not limited to):
    - Established credibility and track record of working in partnership with the GOI;
    - Ability to influence GOI programs and policies.

For the purpose of this proposal, the applicant will use the Public Health Foundation of India (PHFI) and IndiaCLEN as two example SSIs. The PHFI contact person is Ms. Ruhi Saith, Head Research Programs who can be reached at office phone number 91-11-46046000 and the IndiaCLEN contact person is Prof. Kurien Thomas and his email address is kurien123@hotmail.com. The applicant will need to demonstrate how it would work with these institutions to meet the objectives of this project. Applicants also may identify up to three additional potential SSIs and demonstrate how they would work with them to

meet the objectives of this project. Applicants should provide an analysis of constraints and challenges to effective MNCHN programs in India, propose priority areas where MCH STAR may provide support to address these constraints and challenges, and justify SSI partner profile and selection based on this analysis.

2.3 Capacity building of MCH STAR-Supported Institutions

The applicant will propose a process for detailed development of a capacity plan for the SSI's, and provide example plans for each proposed SSI. The capacity building plan should be closely linked to the provision of MCH STAR technical assistance services. Specifically, respondents should focus on skills that will build a SSI's capacity to provide high-quality, responsive technical support services in MNCHN, including the range of services to be provided by MCH STAR.

2.4 Operations, Applied and Policy-related Research

- The applicant will propose a plan to identify program implementation impediments, knowledge gaps and research priorities in MNCHN with the GOI, state governments, professional associations and other stakeholders. USAID anticipates the SSI will take the lead in convening or facilitating this process. The applicants will:
    - Demonstrate the role they see the SSIs playing in this process;
    - How the applicant will support the SSIs in their roles;

- The applicant will propose how it will work with SSIs to develop a research plan.

- In relation to the research plan, the applicant will propose a plan for:
    - Implementing and monitoring research activities
    - Maintaining research quality;
    - Meeting the SSIs' technical assistance needs in relation to the research; and
    - Managing the technical assistance given to the SSIs.

- Applicants will specify whether they see the need for other, non-SSI institutions to lead research activities. If so, they must:
    - Explain why it is necessary.
    - Explain how these non-SSI institutions and activities will interact with SSIs.
    - Define a process for soliciting proposals and selecting the non-SSI institutions.
    - Identify and address differences in the management of these research activities, when compared to those of the SSIs.

- The applicant will propose and explain a process for identifying which SSI, and which office or investigator within a specific SSI, will lead a given research program.

- The applicant will provide an analysis of the types of research needs and expertise required, and then specifies where key resources will be found in proposed SSIs. Such expertise is expected to include, but not necessarily be limited to the following areas: Descriptive epidemiology and observational studies, community intervention trials, program evaluations and evaluation research, design of operations and applied research studies, analysis of large demographic data sets such as NFHS, formative and qualitative research, and health systems research. Where required, sources of non-SSI expertise will be proposed.

2.5 Policy Analyses, White Papers and Advocacy

The applicant will propose a plan to identify key MNCHN issues where policy analyses, white papers, and advocacy efforts may lead to improvement in the performance of national MNCHN programs. The plan should work with the GOI, state governments, professional associations and other stakeholders. Again, USAID anticipates the SSIs will take the lead in convening or facilitating this process. Applicants will:

  - Demonstrate the role they see the SSIs playing in this process;
  - How the applicant will support the SSIs in their roles;

- The applicant will propose a plan to support SSIs in implementing these identified policy analysis, advocacy and white paper activities. In relation to the plan, the applicant will discuss how it will:
  - Monitor the activities
  - Maintain quality;
  - Meet the SSIs' technical assistance needs in relation to these activities; and
  - Manage the technical assistance given to the SSIs.

- Applicants will specify whether they see the need for other, non-SSI institutions to lead these activities. If applicants feel TA from such resources is necessary, they must:
  - Defend why it is necessary
  - Explain how this non-SSI TA will interact with SSIs.

- The applicant will develop a process for selecting which SSI or which departments or individual within a SSI will conduct specific policy analysis, white paper development and advocacy activities.

2.6 Technical Assistance

- The applicant will propose a plan to identify MNCHN technical assistance needs with the GOI, state governments, and other stakeholders;

- The applicant will propose a plan to identify the MNCHN technical assistance needs of the SSIs;

- The applicant will propose a plan for prioritizing and processing the unsolicited requests for MNCHN-related TA from the GOI and other MNCHN institutions.

In relation to each of these three points, the applicant will:

  - Describe the process to identify and to respond to TA needs;
  - Describe the process for deciding whether TA requests can be met by a SSI;
  - Describe the process for selecting which SSI or which departments or individual within a SSI will conduct provide the TA;
  - The process for selecting non-SSI TA resources when SSIs are unable to meet TA needs.

- The applicant must demonstrate it has the means to quickly procure TA from non-SSI bodies (in India or on the international market) where the price and quality is competitive with that provided through USAID's US-based technical projects.

- In the case of TA procured from non-SSIs, the applicant will demonstrate how this TA will interact with the SSIs and contribute to SSI capacity development.

- The applicant will propose a plan to support SSIs in implementing these technical assistance activities. In relation to the plan, the applicant will discuss how it will:
  - Monitor and evaluate SSI performance
  - Maintain quality;
  - Meet the SSIs' technical assistance needs to ensure quality, timeliness and to build capacity; and
  - Manage any such technical assistance given to the SSIs.